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Chapter 6
Status of Tobacco Prevention and Control Programs in the Americas

Preface

The Americas comprise diverse countries that have not developed synchronously. The impact of many of the factors of development discussed in the previous chapters—the transition to an industrialized economy, the changing population structure, the consolidation of the tobacco industry, the growing prevalence of cigarette smoking, and the emerging burden of smoking-attributable mortality—has differed among countries. Almost all countries have some form of antismoking activity, but the nature and extent of that activity are shaped by historical, epidemiologic, economic, and legal factors specific to each country.

The current antismoking activities of governments and other agencies are described in this chapter. These activities illustrate the diversity of the public health response to tobacco use. The emphasis here is on the types of activities, rather than specific content and detail. Surveillance, monitoring of prevalence, taxation, and legislation are revisited to provide a comprehensive overview of the current antismoking movement.

Introduction

Elements essential to the prevention and control of tobacco use, described in reports on developing and developed countries,[1] include surveillance, education, taxation, legislation, and coalition building. These elements must be developed in the sociodemographic and economic context of each country in the Americas, and they must account for the unique nature of the epidemic of tobacco use in each country. Some elements, such as taxation, are beyond the responsibility of ministries of health, and all the elements require the collaboration of other ministries, professional organizations, the media, church groups, and community coalitions. Concerted efforts of both government agencies and private or nonprofit organizations are necessary for successful tobacco control (Jamison and Mosley 1991). The current, documented tobacco-control activities of governments and other agencies are reviewed here to provide an overview and summary of content described in detail in previous chapters.

National Programs for Tobacco Control

United States

In the United States, the public health practice of tobacco control has evolved during the past 25 to 30 years as federal, state, and local governments have joined voluntary health agencies in prevention activities. The 1964 advisory committee report to the Surgeon General on the health consequences of smoking provided the scientific information needed to launch an effective, sustained, national public health campaign against tobacco use (Public Health Service 1964). As the national effort matured, the actions of state and local health departments became more important, since municipalities have more opportunities for aggressive control. Funding and technical assistance for state and local efforts has come from voluntary agencies and, more recently, from the Public Health Service—primarily the National Institutes of Health (the National Cancer Institute [NCI] and the National Heart, Lung, and Blood Institute), and the Centers for Disease Control (CDC). The CDC Office on Smoking and Health (OSH) was designated the lead organization for tobacco issues, and the lead spokesperson is the Surgeon General—largely because of the federally mandated annual report of the Surgeon General on the health consequences of smoking.

The Department of Health and Human Services (USDHHS) has periodically set national goals for the reduction of tobacco use among residents of the United States, but no coordinated program represents all departments of the federal government. In 1990, the Secretary of Health and Human Services released the year 2000 health objectives for the nation, and tobacco use was addressed by these objectives (USDHHS 1990a). The objectives call for (1) a reduction (to 15 percent) in the prevalence of adult smoking, (2) a reduction (to no more than 15 percent) in the rate of initiation of smoking by persons less than age 20 (as measured by the prevalence of smoking among 20 to 24 year olds), (3) an increase (to 50 percent) in the proportion of smokers who quit smoking for at least one day each year, (4) an increase (to at least 60 percent) in smoking cessation beginning in early pregnancy, (5) a reduction (to 20 percent) in the proportion of children aged 6 or younger who are exposed to tobacco smoke at home, and (6) a reduction (to no more than 4 percent) in smokeless tobacco use among males aged 12 through 24. Additional objectives call for the following:

- For all schools to be tobacco-free and to include prevention of tobacco use within the basic curriculum.
- For an increase to 75 percent in the proportion of worksites that prohibit or severely restrict smoking.
- For enactment and enforcement of bans on the sale of tobacco to minors.
- For the development of state tobacco-control plans.

1 Gray and Daube 1980; Pan American Health Organization 1989a; World Health Organization 1979, 1983a,b; Chapman and Wong 1990; Pierce 1991; Novotny et al., in press; Choi et al., 1991; Davis, Monaco, Romano 1991; Centers for Disease Control 1991.

- For a ban or severe restriction on advertising and promotion of tobacco to which youths are likely to be exposed.
- For an increase to 75 percent in the proportion of health care providers who provide smoking cessation advice and assistance to their patients.

NCI has encouraged the integration of effective cancer control technology (including tobacco control) into existing health care delivery systems. Interventions include school-based programs, testing and dissemination of minimal interventions (such as self-help programs), training of health care providers, mass media efforts, programs for groups at high risk for tobacco use, and programs to control the use of smokeless tobacco (Cullen 1988; USDHHS 1990b).

Additional support for state activities has been achieved through state cigarette excise taxes dedicated to tobacco-control programs (Bal et al. 1990) and through ASSIST (American Stop Smoking Intervention Study), a seven-year project sponsored jointly by NCI and the American Cancer Society. ASSIST, which began in 1991, will provide about $120 million to 20 states or large metropolitan areas for tobacco control (McKenna and Carbone 1989). The goal of ASSIST is to reduce by 43 percent the prevalence of smoking in the participating areas by 1998. ASSIST is expected to help achieve the year 2000 health promotion objectives for tobacco use.

The 1989 report of the Surgeon General, *Reducing the Health Consequences of Smoking: 25 Years of Progress* (USDHHS 1989), details the accomplishments of U.S. tobacco-control efforts. For the United States, the report documented a yearly decline, since 1979, of 0.5 percentage points in the prevalence of smoking among persons 20 years old or older and a mean yearly percent decrease of 2.4 percent in the adult (≥18 years old) per capita consumption of cigarettes. As a result of these trends, three-quarters of a million fewer smoking-related deaths occurred between 1964 and 1985 than would have occurred had prevalence not diminished (USDHHS 1989).

Canada

The Canadian tobacco prevention and control movement began over two decades ago when educational activities were stimulated by the British Royal College's 1962 report on smoking and health (Royal College of Physicians 1962). In 1985, the National Strategy to Reduce Tobacco Use was launched; its mission statement resolved to "produce a generation of nonsmokers by the year 2000" (McElroy 1990, p. 2). Twenty-two national health agencies created a joint steering committee whose 1987 directional paper presented a framework for the national program. Three principal goals were enumerated: protection of the health and rights of nonsmokers, prevention of smoking among young persons, and availability of cessation programs. To accomplish these goals, seven strategies were identified: legislation, access to information, availability of services and programs, message promotion, support for citizen action, intersectoral policy coordination, and research and knowledge development (McElroy 1990).

Current participants in the national strategy are Health and Welfare Canada, provincial and territorial ministries of health, the Canadian Cancer Society, Canadian Nurses Association, Canadian Council on Smoking and Health, Canadian Medical Association, Physicians for a Smoke-Free Canada, Heart and Stroke Foundation of Canada, Canadian Lung Association, and the Canadian Public Health Association. Health and Welfare Canada, through its Tobacco Programs Unit, is the coordinating agency. The Non-smokers' Rights Association is not a participating member of the national strategy but plays a major role in tobacco control in Canada.

Legislation has been a particularly strong component of the national strategy. The Tobacco Products Control Act, which came into force January 1, 1989, phased out all forms of tobacco advertising in print and broadcast media, on billboards and mass transit posters, and on point-of-sale signs. The act prohibits the free distribution of tobacco products, prohibits the display of tobacco trademarks on nontobacco items, restricts tobacco company sponsorship to events sponsored before 1987, and requires tobacco product packages to prominently display health messages and to list toxic constituents of tobacco smoke (Kyle 1990). The Non-Smokers' Health Act (effective December 29, 1989) bans smoking or restricts it to just a few areas in conveyances, public places, and workplaces under federal jurisdiction. About 900,000 workers, or 8 percent of the Canadian work force, are affected (Kyle 1990). Retail taxes average US$3.70 for a pack of 20 cigarettes (Claiborne 1991).

Using the slogan "Break Free for a New Generation of Non-Smokers," the national campaign has brought together key groups and individuals and has encouraged cooperation, coordination, and comprehensiveness. Between 1980 and 1989, the prevalence of smoking among teenagers in Canada decreased by almost 50 percent (Stephens 1991), while it remained constant among high school seniors in the United States (Johnston, O'Malley, Bachman 1987). Tobacco prevention and control in Canada, along with that of the French overseas departments and territories (see Chapter 5), is the most comprehensive in the Americas.

Regional Activities for Tobacco Control in Latin America and the Caribbean

In 1984, the Pan American Health Organization (PAHO) held a meeting in Punta del Este, Uruguay, on programs for control of noncommunicable diseases (PAHO 1988a). This effort was followed by an advisory group recommendation to hold subregional workshops to identify strategies and obtain political commitment for tobacco control in member countries. Workshops on control of smoking were subsequently held for the Southern Cone and Brazil in 1985 (PAHO 1986), the Andean Area in 1986 (PAHO 1987a), the English-speaking Caribbean in 1987 (PAHO 1988b), and Central America in 1988 (PAHO 1989b). At these workshops, representatives of each subregion reported on activities related to tobacco control, including surveillance, regulatory policies, educational programs, and media activities. PAHO emphasized the need for plans of action to include efforts from government health and education agencies and from cultural, sports, communications, trade, legislative, and agricultural programs. PAHO also encouraged member countries to set up a central office for tobacco control in each ministry of health (PAHO 1988a). The World Health Organization (WHO) requested that each country identify a focal point for tobacco or health activities (WHO 1986).

In 1989, a Regional Plan of Action for the Prevention and Control of Tobacco Use was released by PAHO at the thirty-fourth meeting of its Directing Council (PAHO 1989a). The plan was accompanied by a resolution urging member governments to institute the plan and encouraging the PAHO Director to mobilize extrabudgetary resources for implementing the plan. Elements of the plan are as follows:

Promotion of policies, plans, and programs. Provide information on control strategies to various agencies; collaborate in the formulation of national policies; and develop workshops and meetings, demonstration projects, guidelines for national programs, legislative strategies and enforcement, and minimum indicators essential for program evaluation.

Mobilization of resources. Identify government and nongovernment organizations and individuals that can contribute to the plan; involve WHO collaborating centers in mobilizing resources; collaborate with professional associations and political leaders; and collaborate with educational, health, and transportation services in providing smoke-free facilities.

Management and dissemination of information. Identify agencies that provide tobacco-related educational material, involve mass media in dissemination of such information, and evaluate its dissemination through a regional information network.

Training. Identify training needs and train program managers and health professionals.

Research. Conduct applied research on overall program efficacy, on smoking among adolescents and other high-risk groups, and on effectiveness of cessation programs.

Technical advisory services. Provide direct advice from PAHO staff or consultants to requesting countries.

Because this regional action plan is so recent, its implementation and impact have not yet been evaluated in depth. Nonetheless, the plan is commendable for having identified the factors important to tobacco control and for having encouraged participating countries to develop coordinated programs.

The Caribbean Community (CARICOM), an organization of heads of governments from the Caribbean area, recommended in 1987 that all members participate in a Regional Program for Drug Abuse Abatement and Control. Tobacco is included in the program, and education is the main focus of intervention activities. Other components include treatment, data collection, and the establishment of national councils on drug abuse. Many Caribbean countries have established these councils (Appendix 2), which bring national attention to tobacco as a gateway drug and to the need for education to prevent tobacco use by young persons. No evaluation studies or reports on these councils are available.

Since 1980, the International Union Against Cancer has joined public and private health leaders in 18 countries of the Americas in organizing national workshops on smoking and health. International voluntary agencies have provided assistance to these workshops, in which 6,000 physicians, educators, health officials, and community activists have participated. Several countries have established national plans for tobacco control, which include research on prevalence of smoking and smoking-related diseases, educational campaigns on the health consequences of smoking, and comprehensive smoking-related health policies.

In January 1985, leaders of tobacco-control activities formed the Latin American Coordinating Committee on Smoking Control (LACCSC) (American Cancer Society [ACS] 1988), which has the following goals:

- To help coordinate smoking-control efforts throughout Latin America.

- To provide a clearinghouse for information supportive of national smoking-control initiatives.
- To provide a forum for planning multinational strategies.
- To provide guidance and training in smoking-control advocacy skills.
- To adopt resolutions calling for action by governments throughout the region.

By using funding from the International Union Against Cancer and the American Cancer Society (ACS), LACCSC, in partnership with PAHO, has distributed a newsletter several times a year, has developed a model smoking-education curriculum, and has developed guidelines for smoking-control coalitions and media advocacy. Workshops on working with the media, fostering advocacy, and calculating smoking-attributable mortality have been held in conjunction with LACCSC annual meetings. LACCSC has supported national coordinating committees, national plans of action, and World No-Tobacco Day (May 31 of each year).

In 1991, the Association of Latin American Women for the Control of Smoking was formed at the seventh annual LACCSC meeting to help prevent smoking among women and to combat tobacco advertising directed toward women. Initial goals include data collection and reporting on smoking among women and coordination with other multinational organizations concerned with smoking among women (ACS 1988).

Elements of Prevention and Control Programs

The information presented here derives from joint work of PAHO and the CDC Office on Smoking and Health. In 1988, a questionnaire was developed, and an in-country investigator identified for each Latin American and Caribbean country completed the questionnaire (PAHO 1992). Information and documentation about the overall prevention and control of tobacco use were requested, along with specific data on the main control elements. The findings are presented in detail in a companion report (PAHO 1992). The overview of the findings presented here emphasize the diverse nature of tobacco-control activities in Latin America and the Caribbean.

Surveillance and Analysis

A comprehensive system for surveillance of tobacco-related events would include surveillance of the following: (1) adult, adolescent, and special populations (such as women and physicians) to determine current and former use of tobacco, rate of smoking initiation, and rate of smoking cessation; (2) public knowledge, attitudes, and beliefs about tobacco use; (3) interventions, such as the prevalence of restrictions on smoking at worksites and the extent of antismoking education in schools; (4) legislative and regulatory activity, both proposed and enacted (Novotny et al., in press); and (5) trends in tobacco products. Many Latin American and Caribbean countries have some elements of a surveillance system, but none appears to have all elements (PAHO 1992).

Most Latin American and Caribbean countries have conducted some form of an adult survey on tobacco use (Chapter 3, Table 16), but the methods, sample size, target groups, sampling methodology, and questions of these surveys have varied considerably. The survey questions used have been recommended by the International Union Against Cancer (Gray and Daube 1980), used for the U.S. National Health Interview Survey (USDHHS 1989), or derived from other sources.

Small, non-population-based samples of adults were generally drawn for one-time surveys. In some countries, including Colombia, Jamaica, and Mexico, questions on tobacco use were included in surveys of drug use (PAHO 1990). In the U.S. Virgin Islands, CDC's Behavioral Risk Factor Surveillance System (BRFSS) has been used each year since 1988 to survey adults aged 18 years or older about smoking, lack of exercise, contraceptive use, lack of seatbelt use, and other risk factors (PAHO 1992). The BRFSS permits trend analyses of behaviors over time and helps identify population risk patterns. No Latin American or Caribbean country other than the U.S. Virgin Islands has periodically monitored tobacco use in the general population.

The diverse methodologies limit analysis and conclusions for specific countries and the region as a whole. For example, if occasional smokers were included in the category for current daily smokers, the reported prevalence of current smoking may have been increased. Furthermore, samples were often

drawn from urban areas, and since the prevalence of smoking is higher among urban than nonurban dwellers (Chapter 3, "Prevalence of Smoking in Latin America and the Caribbean"), national inferences cannot be drawn.

Several countries have also surveyed groups at high risk for tobacco-related disease. Because of the well-documented effects of maternal tobacco use on infant health (Malloy et al. 1988), women of reproductive age (15 to 44 years old) have often been surveyed (Chapter 3, Tables 11–18). Women of reproductive age in the Americas were asked about tobacco use in eight surveys conducted with assistance from CDC and in 10 surveys performed by PAHO's Latin American Center for Perinatology and Human Development (PAHO 1987b).

Several Latin American and Caribbean countries have surveyed youths about cigarette smoking (Chapter 3, Table 17), but the definitions used for categories of smokers were again quite variable. Furthermore, the surveys may have missed an important segment of the young population because most of them were performed in schools. In many of these surveys, questions about tobacco use were part of drug-use surveys; because tobacco is addicting, it is considered a substance that can lead to the use of other drugs (Fleming et al. 1989). In the United States, school-based surveillance of behavioral risk factors is accomplished through a uniform survey instrument, the Youth Risk Behavior Survey (Harel et al. 1990). Standard questions on ever use of cigarettes, use of cigarettes in the last 30 days, and current daily use of cigarettes are included in this survey. Persons aged 12 to 18 are surveyed because, in the Americas, initiation of smoking generally occurs in this age group.

Physicians are generally educated about the health consequences of smoking, and their health-related behavior may set an example for other persons (Adriaanse and Van Reek 1988). Prevalence of smoking among physicians may be an indicator of diffusion of the nonsmoking norm and of a society's willingness to combat the health consequences of smoking (Pierce 1991). In several Latin American countries, the prevalence of smoking among physicians and physicians-in-training has generally been similar to or only slightly lower than that in the general population (Chapter 3, Table 16).

Surveys in Latin America and the Caribbean have often not included questions on knowledge, attitudes, and beliefs regarding tobacco (Chapter 3, Table 18). This information is important for monitoring the effect of public information campaigns (Pierce 1991) and in tracking public support for legislative and policy interventions. Data from youth surveillance may be extremely helpful when establishing school-based educational programs.

But data on tobacco use must be collected in a standardized way to allow for planning and evaluation of national programs and comparison of trends within and between countries. Furthermore, the key variables of a surveillance system should not be modified significantly over time. In 1990, WHO convened an internal working group to update standard measures of tobacco use. Standard definitions for worldwide surveillance have not yet been agreed upon, but WHO continues to pursue consensus for worldwide surveillance (WHO 1983a, 1988).

A recent example of surveillance of tobacco products serves to demonstrate the value of a coordinated, regional approach. Under the sponsorship of PAHO, the Health Protection Branch of Health and Welfare Canada measured the tar, nicotine, and carbon monoxide yield from popular cigarette brands in 20 countries (Table 1). The results suggest that smokers in most Latin American and Caribbean countries are exposed to levels of toxic constituents similar to those to which North American smokers are exposed (e.g., 14 to 18 mg of tar per cigarette). Continued monitoring of product characteristics is an important component of surveillance of tobacco-related disease.

More than half the world's deaths due to cancers and cardiovascular disease and 85 percent of deaths due to chronic obstructive pulmonary disease occur in developing countries. To assess the cost and effectiveness of intervention strategies against several chronic diseases, The World Bank commissioned a series of studies that incorporated economic, epidemiologic, and clinical data for developing countries (Jamison and Mosley 1991), most of which lacked empirical data about many of the major chronic diseases of adults. The lack of data systems that enable analyses of mortality trends and of trends in determinants of chronic diseases now hampers meaningful policy and program development.

Education, Public Information, and Cessation Programs

School-based educational activities against tobacco are uncommon in Latin America and the Caribbean, but through the efforts of LACCSC, ministries of health and education, and nongovernment organizations, several countries have begun to include antitobacco education in school curricula (see Appendix 1). Few of these programs have been evaluated; however, a 1988 antitobacco education program in Chile, initiated with the assistance of WHO, has been evaluated by the Ministry of Health in Chile. This evaluation

Table 1. Selected data for popular brands of cigarettes in 20 countries

Brand name*	Country	Tar (mg/cig)	Nicotine (mg/cig)	Carbon monoxide (mg/cig)	Filter type	Market share (%)
Derby KS FT	Argentina	13.44	0.90	15.46	Acetate	14.0
Jockey Club KS FT	Argentina	14.16	0.96	16.85	Acetate	5.3
L&M KS FT	Bolivia	14.82	1.07	17.38	Acetate	48.4
Astoria	Bolivia	21.79	1.60	17.56	None	16.6
Belmont KS FT	Brazil	19.93	1.48	19.51	Acetate	19.1
Mustang KS FT	Brazil	14.44	0.85	18.20	Acetate	4.1
Players Light RS FT	Canada	14.86	1.34	15.21	Acetate	12.9
Export A RS FT	Canada	15.03	1.27	15.91	Acetate	5.7
Derby Superlongs PS FT	Chile	14.64	1.36	18.80	Acetate	24.7
Advance Superlongs PS FT	Chile	8.69	0.70	10.75	Acetate	11.9
Pichoja RS P	Colombia	23.79	1.58	16.31	None	21.7
Delta KS FT	Costa Rica	16.20	1.24	19.04	Acetate	53.7
Derby KS FT	Costa Rica	16.08	1.35	15.98	Acetate	21.6
Marlboro RS FT	Dominican Republic	15.45	1.17	15.88	Acetate	51.1
Cremas KS P	Dominican Republic	21.77	0.98	18.77	None	3.5
Lark KS FT	Ecuador	14.90	1.06	17.31	Acetate/ charcoal	36.1
Lider Suave KS FT	Ecuador	13.01	0.90	16.32	Acetate/ charcoal	31.3
Delta PS FT	El Salvador	18.02	1.12	18.67	Acetate	57.3
Diplomat deLuxe 100s PS FT	El Salvador	18.60	1.14	20.10	Acetate	15.6
Rubios KS FT	Guatemala	14.99	0.85	15.90	Acetate	28.6
Belmont KS FT	Guatemala	14.28	0.64	16.62	Acetate	16.9
Royal KS FT	Honduras	13.39	1.05	14.48	Acetate	39.0
Belmont KS FT	Honduras	13.65	1.07	15.73	Acetate	23.0
Craven A RS FT	Jamaica	17.68	1.51	14.12	Acetate	76.7
Raleigh RS FT	Mexico	15.87	0.85	17.44	Acetate	22.9
Delicados Oscuros RS FT	Mexico	14.33	0.73	17.66	Acetate	8.4
Viceroy KS FT	Panama	15.15	1.05	15.04	Acetate	32.7
Marlboro KS FT	Panama	14.78	0.96	15.02	Acetate	19.3

Table 1. Continued

Brand name*	Country	Tar (mg/cig)	Nicotine (mg/cig)	Carbon monoxide (mg/cig)	Filter type	Market share (%)
Union Club PS FT	Paraguay	18.15	1.00	17.77	Acetate	—
Clayton 100s PS FT	Paraguay	21.39	1.87	20.10	Acetate	—
Broadway Extra RS FT	Trinidad and Tobago	14.53	1.20	13.26	Acetate	—
du Maurier RS FT	Trinidad and Tobago	15.29	1.38	14.34	Acetate	—
Nevada KS FT	Uruguay	15.55	1.41	14.10	Acetate	76.8
Casino KS FT	Uruguay	16.06	1.34	20.43	Acetate	23.2
Marlboro KS FT	United States	17.00	1.20	17.00	Acetate	12.3
Winston KS FT	United States	17.00	1.10	16.00	Acetate	4.0
Belmont Extra Suave RS FT	Venezuela	15.43	0.92	16.01	Acetate/ charcoal	45.7
Astor Super Suave RS FT	Venezuela	15.09	0.85	16.37	Acetate/ charcoal	—

Source: Collishaw, unpublished data (1991).
*Codes refer to product types, where KS = king size, FT = filter tip, RS = regular size, PS = premium size, and P = plain.

suggested that school-based education was effective in preventing the uptake of smoking by younger adolescents but was ineffective in persuading adolescents who were already smokers to stop smoking (Sepulveda 1990). By the end of the intervention, 3.2 percent of students in the intervention group were daily smokers, versus 10 percent of students in the nonintervention group.

Programs in a few Latin American and Caribbean countries rely on physicians to provide information to patients visiting government facilities. In Cuba, the National Program to Reduce Cancer Deaths uses the islandwide system of primary-care providers. An 18 percent decrease in smoking prevalence was reported in communities with intervention sites and a 4 percent decrease at nonintervention sites (Suárez-Lugo 1988).

Public information campaigns focus attention on tobacco as a serious health issue and help craft prevention and cessation messages for target audiences. Formal public information programs train public health professionals in communications, and these persons can then build working relationships with local media (Erickson, McKenna, Romano 1990). In 1990, most countries in the Americas reported some public information activity on tobacco use. In many Latin American and Caribbean countries, public information activities have revolved around a "smokeout" day similar to the ACS's Great American Smokeout held on the third Thursday in November each year in the United States (CDC 1990a). Many countries have promoted the WHO-sponsored World No-Tobacco Day, held on May 31 each year (CDC 1991). WHO has distributed press packets and video messages in several languages, including Spanish, for this event. Furthermore, public information announcements broadcast in the United States may be viewed in Caribbean countries on cable networks.

Education and public information activities in the Americas have increasingly focused on use of drugs, including tobacco. Efforts have included both school-based education and public information campaigns. Many organizations in the Americas that address tobacco use are responsible primarily for drug-abuse prevention.

Cessation programs, an important component of tobacco-control programs (Novotny et al., in press), have been regularly provided by the Seventh-Day Adventist Church in many countries of the Americas. The church has strong tenets against several health

risk-factors, including smoking, using alcohol, and eating meat. The standard five-day classes, which are open to the public, include a spiritual approach to health issues (Proctor 1985). A few countries report that other private smoking-cessation programs are sporadically offered. No information is reported on widely available, self-help cessation programs, such as those used effectively in the United States (Glynn, Boyd, Gruman 1990). But most smokers quit without the aid of formal programs and may rely on minimal interventions (e.g., those that provide the skills and information necessary for persons who want to quit smoking) (Fiore et al. 1990). Because smoking behavior patterns in many Latin American and Caribbean countries differ from those in the United States, minimal interventions may have to be adapted to specific cultures. More information is needed on public knowledge, behavior patterns, and methodologies effective for developing such interventions.

Taxation

The World Health Assembly has recognized the potential of taxation as a tool for the control of tobacco use (WHO 1986). Among the countries of the Americas for which data are available, variability is wide in the type of taxes levied, their contribution to the price of tobacco and cigarettes, and the proportion of government revenue they generate (see Chapter 4, "Economics of the Tobacco Industry"). In Peru, for example, cigarette taxes are only 16 percent of the price of cigarettes, but in Colombia, taxes are 120 percent of the price (Table 2). Tariffs vary from 14 percent to 130 percent of the price of manufactured cigarettes. Tax as a percentage of total central government revenue also varies substantially; however, assessment is complicated because different revenue generating and collecting systems are used by Latin American and Caribbean countries.

Table 2. Tobacco tax and tariff in selected countries of the Americas, 1988 or earlier

Country	Tax (as % of price)*	Tariff (as % of price of manufactured cigarettes)†	Tax (as % of total government revenue)*
North America			
Canada	75	20	2.4
United States	35‡	14	1.9
Latin America			
Argentina	75§	36	22.5
Brazil	76	105	7.4
Chile		15	5.6
Colombia	120	50	13.2
Cuba‖			1.8
Ecuador		90	
El Salvador		80	
Guatemala		80	4.7
Haiti		130	41.3
Mexico	57	20	1.1
Peru	16	110¶	2.8
Venezuela	45	35	2.7
Caribbean			
Suriname		50	
Trinidad and Tobago		20	

Source: U.S. Department of Agriculture (1984, 1989); Agro-economic Services Ltd. and Tabacosmos Ltd. (1987); U.S. Department of Health and Human Services (1989).
*1983.
†1988.
‡Includes state taxes.
§1987.
‖Government tobacco monopoly.
¶Includes 24% surcharge; import of cigarettes is banned.

Tobacco taxes may be dedicated for specific health purposes. Several states in the United States have used cigarette tax revenues to finance tobacco-related health programs, and the most substantial program of this kind is in California. In November 1988, the state's cigarette tax was increased from 10 cents to 35 cents per pack. Three-quarters of the revenues from this tax increase are used for health education, research, medical treatment, and environmental conservation programs (Tobacco Tax and Health Protection Act of 1988; Bal et al. 1990).

But the level of taxation is not necessarily an indicator of concern for health. For example, in Canada, where taxes add an additional 75 percent to the price of cigarettes, health concerns and a concerted antismoking movement have strongly influenced policy. But in several Latin American countries where the level of taxation is as high or higher (Table 2), health concerns may not have been a strong influence. Throughout Latin America, the influence of health concerns on level of taxation has varied (PAHO 1992).

Data regarding tobacco taxation for 1989 or later (Table 3) differ somewhat from the information reported earlier (Table 2). These differences may reflect short-term changes in taxation policy, but they may also reflect differences in the methods used to calculate the proportion of tobacco price and the proportion of government revenue contributed by tobacco tax.

Legislation

The legislative efforts to control tobacco use in the Americas are extensive (see Chapter 5), but how well the written laws are enforced in day-to-day life is unclear. In the United States, for example, laws in most states ban cigarette sales to minors, but these laws are rarely enforced (CDC 1990b). Systematic information on enforcement in the Americas is not available.

Table 4 summarizes tobacco-control legislation in the Americas—the base on which continued efforts are expanding. Some key points about the legislation are given below. (The French overseas departments and territories are counted as Caribbean countries, as in Chapter 5.)

- Fifteen Latin American and four Caribbean countries have either a total ban on or some type of legislation restricting advertising and cigarette promotion.
- Three countries prohibit all advertising of tobacco.
- Bolivia limits advertising to the tombstone format, which allows print and a picture of the package.
- Two countries—Argentina and Bolivia—prohibit advertising associated with sports.
- Sixteen countries restrict advertising that influences young people.

Table 3. Excise taxes on manufactured cigarettes as percentage of total retail price and of total national tax revenue, 1989 or most recent year available

Country	Retail price	Tax revenue
Andean Area		
Bolivia*	61†	1.4
Peru‡	55§	0.1
Venezuela‖	50	2.5
Southern Cone		
Argentina	75	22.0
Chile	75	10.0
Paraguay	10/35¶	8.6
Uruguay	60	5.0
Brazil	73	5.0–7.0
Central America		
Costa Rica	75	5.0
El Salvador	43	21.0
Guatemala		3.0
Panama	60	2.0
Mexico		1.7
Latin Caribbean		
Dominican Republic	13	2.3
Haiti	41	
Puerto Rico	39	3.0
Caribbean		
Aruba	64	
Bahamas	48	
Barbados	41	
British Colonies**	Tax free	
French overseas departments and territories††	75	
French Guiana	52‡‡	
Guyana	50	35.0‡‡
Jamaica	42	4.0
Netherlands Antilles	Tax free	
Organization of East Caribbean States		
St. Lucia	18	0.5
Dominica	35	1.0
St. Vincent and the Grenadines	41	1.0
Suriname	55	
Trinidad and Tobago	15	1.1
U.S. Virgin Islands	4	

Source: Pan American Health Organization (1992).
*1987.
†17% surtax on imports.
‡1988.
§7% of taxes allocated to cancer hospital.
‖Average 1978–1988.
¶Light tobacco/dark tobacco.
**Includes Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat, and Turks and Caicos Islands.
††Except French Guiana. For this table and associated text, the French overseas departments and territories are counted with the Caribbean countries.
‡‡Of consumption taxes.

Table 4. Principal legislative measures* for control of tobacco in the Americas, by type of measure and country

Country†	Restriction on advertising	Advertising ban	Health warning		Statement of tar and nicotine yield
			Rotating or strong	Standard	
North America					
Canada		X	X		X
United States‡	X		X		
Latin America					
Argentina	X			X	
Bolivia	X			X	
Brazil	X			X	
Chile	X		X		
Colombia	X			X	
Costa Rica	X		X		
Cuba		X			
Ecuador	X			X	X
El Salvador	X			X	
Guatemala					
Honduras					
Mexico	X			X	X
Panama	X			X	
Paraguay	X			X	
Peru	X			X	
Uruguay	X			X	X
Venezuela	X			X	
Caribbean					
Bahamas	X		X		
Barbados				X	
Bermuda	X		X		X
French overseas departments and territories§		X	X		X
Trinidad and Tobago	X			X	X

Source: Copies of national legislation provided by individual countries to the Pan American Health Organization.
*Provisions of the legislation are summarized in Chapter 5, Appendix 1, notes to Tables 2, 4, 5, and 6.
†The countries listed are those in the Americas that have any type of legislative control of tobacco use.
‡Does not necessarily imply federal legislation, but acknowledges activities of several states.
§For this table and associated text, the French overseas departments and territories are counted with the Caribbean countries.

Restriction on smoking		Prevention of smoking among young people	Health education
In public places	In the workplace		
X	X	X	X
X	X	X	X
X		X	
X		X	X
X	X	X	X
X		X	X
		X	X
X	X	X	X
X	X	X	X
		X	X
		X	X
X			
X			
X		X	X
X		X	
X		X	
X		X	
X	X	X	X
X		X	
X			
X	X	X	X
X		X	

- Nearly all countries that have legislation on advertising require health warnings in advertisements.
- Two countries specify the frequency and duration of health warnings required on the broadcast media.
- Fourteen Latin American and five Caribbean countries require health warnings on cigarette packages.
- Two Latin American countries require strong health warnings, but none requires multiple warnings used in rotation, as do Canada, the United States, and the French overseas departments and territories.
- Only three Latin American countries, three Caribbean countries, and Canada require a statement of tar and nicotine yield on cigarette packages.
- Restrictions on where cigarettes can be sold are generally not found in Latin American and Caribbean countries.
- The State of Rio Grande do Sul, Brazil, prohibits the sale of cigarettes in any establishment subsidized by the government and recommends that tobacco not be sold in hospitals and health services institutions.
- Nineteen countries restrict smoking in public places.
- Seven countries ban smoking on work premises, and thirteen ban smoking in health establishments.
- In the United States, a major statement on the hazards of smoking in the workplace has been issued (National Institute for Occupational Safety and Health 1991).
- Nineteen countries have laws that control smoking by young people.
- Thirteen Latin American countries restrict cigarette advertising that influences young people, but only five of these countries prohibit the sale of tobacco products to minors.
- Argentina and Ecuador prohibit free distribution of samples of cigarettes to minors, and Uruguay prohibits the sale of loose cigarettes.
- Nine Latin American and Caribbean countries prohibit smoking and sales of tobacco in schools and places frequented by young people, although many schools may prohibit smoking on school property.
- Eleven Latin American and Caribbean countries mandate health education about the hazards of tobacco use.
- Five Latin American countries mandate anti-tobacco education in schools, but many schools undoubtedly provide such education voluntarily.

Coalitions

A comprehensive tobacco-control program calls for a national smoking and health organization dedicated to the development of policy and the coordination of government and voluntary efforts. The organization may be an official government agency, or it may be a voluntary agency with or without government support. Nongovernment coalitions or commissions may function outside of the government structure but may include representatives from various ministries, usually health and education. In several countries, medical societies, often a part of a larger coalition, have sustained activities against tobacco use.

Several countries in Latin America have established national commissions with a wide range of functions regarding tobacco control: promotion of research, development of policy, provision of education and information, coordination of intergovernment actions, and evaluation of the effects of tobacco-control programs. These national bodies have the capacity to mobilize support from many departments of government and the private sector.

Most national commissions are concerned with measures to control tobacco use rather than the production of tobacco. The Permanent National Advisory Commission on the Control of Smoking is a government agency created in Argentina to advise on and assist with the production, processing, and exportation of tobacco. The commission, which is composed of government officials and representatives of the employers and employees engaged in tobacco production and processing, does not control the use of tobacco.

In the absence of a national smoking and health organization, the tobacco-control effort is usually handled by the ministry of health. In two Latin American countries, legislation sets forth this responsibility. In Bolivia, a 1978 decree makes the Ministry of Social Welfare and Public Health the only agency that can regulate all aspects of the promotion and sale of tobacco that affect health. The decree specifically recognizes that tobacco is harmful to health. In Brazil, legislation enacted in 1986 provides that the Ministry of Health shall promote week-long activities in connection with National No-Smoking Day, observed annually on August 29.

In seven Latin American countries, legislation creates a national smoking and health organization. A 1986 decree in Chile established the National Commission for the Control of Smoking, which includes the Minister of Health as chairperson and the undersecretaries of interior, economic affairs, agriculture, labor, transport and telecommunications, and justice. The commission (1) continually reviews the situation on smoking and assesses the place of the tobacco industry in the economy; (2) coordinates monitoring of the prevalence of smoking; (3) determines the effects of smoking on mortality and morbidity; (4) identifies public and private resources for information, education,

and health care; (5) analyzes legal texts concerning antismoking measures; (6) proposes smoking-control policies; and (7) designs and evaluates medium- and long-term smoking-control activities.

In Ecuador, a 1989 resolution of the Ministry of Public Health created the Interinstitutional Antismoking Committee under the National Bureau for Epidemiological Control and Surveillance. The committee, which comprises representatives from the public and private sectors and is chaired by a representative of the Ministry of Public Health, plans, advises on, and carries out the national program against smoking.

The General Health Law of 1983 in Mexico provides that the Secretariat of Health, the governments of the federated entities, and the Council on General Health in each geographic area shall coordinate activities for the Antismoking Program. The program aims to prevent and treat the illnesses caused by smoking; to educate citizens, especially families, children, and adolescents, about the health effects of tobacco use; and to promote research on the causes of smoking. The federal government of Mexico has entered into agreements with the various states to coordinate smoking-control activities of the National Council Against Addictions. These activities include the following: (1) encouraging legal measures to control smoking, (2) promoting cooperation between federal and state agencies, (3) integrating government activities with those of the private sector, (4) establishing a government center for information and documentation, (5) strengthening surveillance, (6) promoting research, (7) undertaking epidemiologic studies, and (8) undertaking other studies for early identification of persons with smoking-related problems.

In Panama, a 1989 decree created the National Commission to Study Tobacco Use, which was charged with producing a report on the harmful effects of tobacco use and gathering statistical data on progress in combating smoking. The report is to include information on legislation and on progress at the international level on tobacco and health.

A 1988 Ministerial Resolution in Peru created the Permanent National Commission Against Tobacco, which provides information and formulates recommendations on the health risks of smoking. The commission determines the role of the Ministry of Health and other health institutions in combating tobacco use. These agencies provide support and facilities for the commission, which includes representatives from different sectors of society.

In Uruguay, legislation enacted in 1970 provides for a special commission of the Ministry of Public Health, acting in collaboration with the Ministry of Education and Culture, to study the effects of smoking and to disseminate information on the health risks of tobacco use. Legislation proposed in 1988 would create the Bureau for the Control of Smoking, within the Ministry of Public Health, with broad power to (1) conduct epidemiologic studies, (2) coordinate preventive strategies, (3) conduct public education programs (with cooperation from the National Administration of Public Education, the University of the Republic, and other educational organizations), (4) establish maximum levels of tar and nicotine in tobacco products, and (5) develop actions to reduce smoking.

In Venezuela, a 1984 decree of the Ministry of Health and Social Welfare established a permanent national council under the jurisdiction of the Division of Chronic Diseases. The council studies the health problems related to smoking and formulates policies for preventing smoking and smoking-related diseases. The multidisciplinary council is composed of two representatives from the Ministry of Health and Social Welfare (the Chief of the Division of Chronic Diseases, who serves as president, and the Director of Oncology) and representatives from the ministries of agriculture, labor, transportation and communications, justice, environment and natural resources, information and tourism, and youth affairs; the Venezuelan Social Security Institute; the National Academy of Medicine; the Venezuelan Cancer Society; and the Venezuelan Medical Federation. A technical unit, composed of physicians, epidemiologists, political scientists, sociologists, academicians, publicists, and social communicators, supports and coordinates the development of antismoking actions. The Ministry of Health and Social Welfare coordinates educational programs among the agencies represented on the council.

No legislation that establishes national organizations for tobacco policy development is available from Caribbean countries. Although national efforts may occur in other countries as well, they lack the critical support that government sanction provides. Yet the lack of such support does not necessarily vitiate antismoking efforts. In the Americas, nongovernment groups, such as citizens' coalitions, voluntary agencies, and special-interest groups, have effectively promoted good health.

This compendium of legislation and coalitions does not indicate the extent to which tobacco-control activities are implemented. Many of the recently established government and nongovernment commissions on tobacco may still be rudimentary, but some efforts are well established. For Latin America and the Caribbean, a listing of national organizations, sponsors, and activities of these organizations is provided in Appendix 2.

Summary

Activities critical to controlling tobacco use include surveillance of tobacco consumption, collection of excise taxes, and coordination of local, national, and regional efforts. Surveillance data can be used to monitor trends in tobacco use and to provide a basis for targeting populations. The collection of tobacco tax revenue can be used for monitoring tobacco consumption, and such revenue can be dedicated to health-related programs, as has been done in Peru. The coordination of tobacco-control activities augments the scarce resources that any single jurisdiction might have available to it. Communication networks, such as the LACCSC and the Advocacy Institute's GLOBALink electronic bulletin board (ACS 1990), can assist joint efforts.

In many countries of the Americas, the framework for effective tobacco control is in place. As PAHO's Regional Plan of Action for the Prevention and Control of Tobacco Use is implemented, all tobacco-control efforts in the Americas are likely to become increasingly effective.

Conclusions

1. A basic governmental and nongovernmental infrastructure for the prevention and control of tobacco use is present in most countries of the Americas, although programs vary considerably in their degree of development.
2. The need is now recognized, and work is under way, for developing a comprehensive, systematic approach to the surveillance of tobacco-related factors in the Americas, including the prevalence of smoking; smoking-associated morbidity and mortality; knowledge, attitudes, and practices with regard to tobacco use; tobacco production and consumption; and taxation and legislation.
3. School-based educational programs about tobacco use are not yet a major feature of control activities in Latin America and the Caribbean. The few evaluation studies reported indicate that such programs can be effective in preventing the initiation of tobacco use.
4. Cessation services in most countries of the Americas are often available through church and community organizations. Private and government-sponsored cessation programs are uncommon.
5. Media and public information activities for tobacco control are conducted in most countries of the Americas, but the extent of these activities and their effect on behavior are unknown.

Appendix 1. Antitobacco Activities in Latin America and the Caribbean

The antitobacco activities described here include school-based education, public information campaigns, and cessation activities. PAHO (1992) is the source of this summary.

School-Based Educational Activities

Argentina

With help from the Argentine Cancer League, the ministries of health and justice developed an antismoking educational program for 561 secondary schools.

Bahamas

Antitobacco information is minimally included in the antidrug curriculum.

Belize

The Curriculum Development Unit of the Ministry of Education and Pride Belize (an antidrug organization) developed a school health education program that includes information on health and on developing skills for resisting substance abuse.

Bermuda

Antitobacco information is incorporated into the Family Life Education curriculum.

Bolivia

The Ministry of Education and Culture developed a natural science curriculum for the third and fifth years of primary school. The National Commission Against Tobacco Use (CONLAT) offers classes to primary and secondary schools.

Brazil

Materials are sometimes included in curricula, as determined by individual schools or states. Educational materials are widely available.

British Virgin Islands

The health studies curriculum for high school students uses British antitobacco materials.

Chile

The ministries of health and education, health services, and provincial education departments sponsor school-based educational prevention programs that include evaluation. Students aged 13 or older are now included.

Colombia

The Ministry of Education offers a program on preventing smoking and other forms of drug addiction. A booklet, *El Placer de No Fumar* (The Pleasure of Not Smoking), is included in the compulsory behavior and health section of the school curriculum.

Costa Rica

Information on the effects of smoking are included in primary and secondary curricula and in science textbooks. Educational material is provided by the Social Security Fund, and references to smoking have been eliminated from textbooks. The National Antismoking Association sponsors workshops for secondary school students.

Cuba

Since 1991, antismoking education is offered in all schools islandwide, beginning with the seventh grade.

Guatemala

The National Antismoking Commission is planning an educational program for schools. The Youth Congress on Smoking, held in 1990, provided instruction and training on prevention activities.

Guyana

The National Coordinating Council for Drug Education includes tobacco in curriculum development.

Honduras

Lectures on tobacco use are provided to schools by the Institute for the Prevention of Alcoholism and Drug Abuse.

Jamaica

Antitobacco information has been incorporated into the health education curriculum of primary and secondary schools.

Mexico

Antitobacco information is to be included in public primary school textbooks. The national antismoking program has produced booklets for use in schools by youth groups and by parent groups. Universities include tobacco and health material in schools of medicine, psychology, and social work.

Panama

The Ministry of Education is required by law to include information on the health aspects of smoking

in school curricula (science courses during the first year of secondary school).

Paraguay

Antitobacco education is included in some way in grades four through six. An antismoking association has targeted school-based education as a future activity.

Peru

Each year, the National Cancer Institute, the Ministry of Health, and the Ministry of Education sponsor programs in Lima for 50,000 students aged nine to 12.

Puerto Rico

The Puerto Rican Lung Association sponsors contests, nonsmoking day, and an educational campaign in secondary schools, vocational schools, and universities. By giving talks to seventh-grade students, the American Cancer Society reaches 85 percent of public schools and 30 percent of private schools.

Suriname

The Teachers' Union collaborates with the Ministry of Health in training teachers in smoking prevention education.

Trinidad and Tobago

The Ministry of Education includes antitobacco education in the syllabus of the general health education program for primary, junior high, and senior high school students.

Uruguay

General education for grades three through six targets health behavior, environmental pollution, clean indoor air, and tobacco use as a risk factor for disease.

U.S. Virgin Islands

The Department of Education adopted a revised health curriculum that includes a unit on smoking and on prevention of cardiovascular disease.

Venezuela

The Ministry of Education has an official program. Parents, teachers, and students are organized into extracurricular groups to help develop educational messages.

Public Information Campaigns

Anguilla

Television and radio spots, prepared by health care providers, are occasionally aired.

Argentina

Television and radio campaigns are sponsored by the Public Health Foundation. Campaigns directed toward youths were sponsored by the Argentine Cancer League in 1978 and 1983 and by the Ministry of Health and Social Action in 1979, 1980, and 1982.

Barbados

Government and nongovernment agencies focus antitobacco activities around World No-Tobacco Day.

Belize

Medical and dental associations sponsored a television campaign and bumper stickers in 1989. The National Drug Abuse Advisory Council and Pride Belize distribute pamphlets and sponsor billboards discouraging drug and alcohol use. Smoking-cessation messages are aired on cable television.

Bolivia

In 1983, CONLAT sponsored a meeting on cigarettes and cancer. The biennial Tobacco or Health Day is addressed through mass media and public meetings. Children's poster campaigns have been sponsored, and Bolivia observes both a smokeout in November and World No-Tobacco Day in May.

Brazil

On National Antismoking Day, a race is sponsored by the Ministry of Health in 400 cities. The National Program Against Smoking sponsors a school poster contest each year and publishes a newsletter. The Brazilian Medical Association has an official Antismoking Commission. Five million copies of an antitobacco comic book have been distributed.

British Virgin Islands

Print media cover smoking as a risk factor for cardiovascular disease. Public information materials from the United Kingdom are used. Medical associations provide seminars and public information and support World No-Tobacco day. Cable television from the United States provides antismoking messages.

Cayman Islands

Public information materials from the United Kingdom are used. Medical associations provide seminars and public information and support World

No-Tobacco Day. Business and anti-drug-abuse groups are active in smoking control. The Cayman Radio and Government Information Service broadcasts antitobacco messages on the radio. Cable television from the United States provides antismoking messages.

Chile

The National Cancer Society, in partnership with the pharmaceutical industry, sponsors a television campaign. The Association of Laryngectomy Patients has a mobile presentation for use at schools and worksites. The Ministry of Health publishes numerous articles, and World No-Tobacco Day is celebrated by diverse activities.

Colombia

A national no-smoking day, established in 1984, is coordinated by the Colombian Cancer League. Since 1989, the campaign has coincided with World No-Tobacco Day. In 1990, public service announcements from the Public Health Service of the United States were translated and adapted for the Colombian television audience. In 1991, a mass media campaign was begun with the slogan "Smokers: An Endangered Species."

Costa Rica

Printed materials are distributed through hospitals and clinics.

Smoke-free Day is supported by print and electronic media. The Social Security Fund produces television advertisements, and religious radio stations broadcast tobacco-related information. Journalists have been trained on health topics, including smoking.

Cuba

A mass media campaign, the backbone of a government program, includes television announcements, posters, stickers, and T-shirts. Public education, aimed at parents, teachers, physicians, and government employees, emphasizes the effect of smoking on family income. The National Program to Reduce Cancer Deaths has enlisted a large network of family physicians.

Ecuador

The Lung Association sponsors antitobacco education and media messages. A pharmaceutical workers' union sponsors antitobacco information.

El Salvador

The Department of Mental Health (of the Ministry of Public Health and Social Welfare) occasionally provides television messages and conferences on smoking and health.

French overseas departments and territories

Posters, pamphlets, and radio and television programs provided by the French government are infrequently used.

Guatemala

The National Antismoking Commission provides limited public information through the media. The Association of Physicians and Surgeons provides strong antitobacco support.

Honduras

Radio programs occasionally address scientific information on smoking. World No-Tobacco Day is supported through the National Smoking Control Commission.

Jamaica

The National Council on Drug Abuse (of the Ministry of Health), the Jamaican Medical Association, and the Jamaican Cancer Society are active in public information campaigns.

Mexico

A government program disseminates information through print and electronic media. World No-Tobacco Day is supported through various media.

Panama

A prevention program, based on public information, began in 1990 on the local level. Smoking-related information is periodically broadcast on radio and television. The staff of health care facilities are trained about smoking. The National Cancer Association and a civic committee sponsor a smoke-free day.

Paraguay

The Tuberculosis and Lung Disease Association's booklet on the health consequences of smoking has been distributed by pharmaceutical companies to 3,000 physicians. Nongovernment organizations' activities against drug abuse (including tobacco) receive limited radio and newspaper coverage.

Peru

World No-Tobacco Day has been celebrated since 1985, with parades and activities for children. Antismoking posters are displayed in sports centers. A radio campaign against tobacco began in 1989. Information is also disseminated by the Center for Information and Education for the Prevention of Drug Abuse.

Puerto Rico

The Puerto Rican Lung Association sponsors a nonsmoking day, as well as print, radio, and television messages. The local American Cancer Society sponsors community presentations, materials for physicians, and the Great American Smokeout.

St. Vincent and the Grenadines

The government sponsors print materials.

Suriname

Public service announcements are made through television and print media. The National Council on Drug Abuse, the Association of Heart Disease Patients, and the Medical Association of Suriname sponsor a public information campaign.

Trinidad and Tobago

The Cancer Society sponsors Smokeout Day during annual Cancer Week, gives lectures to community groups, and offers no-smoking signs to organizations.

Uruguay

The Office on Smoking Control (of the Ministry of Public Health) produced a program and five-second spots on healthy living for commercial television. Materials were also developed for health care facilities. Community health activities include development of a booklet, *Tobacco and Its Consequences.* The Cancer Society supports the celebration of Clean Air Day, and the Ecological Party supports clean indoor air policies.

U.S. Virgin Islands

The Department of Health supports the Great American Smokeout, and local public service announcements use U.S. materials on the risk of smoking, especially during pregnancy. The American Lung Association sponsors a weekly 15-minute radio program on lung health and uses the Christmas seal campaign to inform the public about the health consequences of smoking.

Venezuela

The Venezuelan Cancer Society and the Tuberculosis and Lung Disease Society have sustained programs, including National Smoke-Free Day, World No-Tobacco Day, 10-minute public service announcements, and interviews with officials of the Ministry of Health and Social Welfare.

Cessation Activities

Argentina

Workshops are conducted by the Public Health Foundation and the Argentine Antismoking Union. Cessation classes are offered by the Argentine Cancer League and the Seventh-Day Adventist (SDA) Church.

Bahamas

Insurance companies offer a nonsmoker life insurance discount of 35 percent.

Barbados

The Barbados Cancer Society conducts five-week smoking-cessation clinics based on the American Cancer Society model.

Bermuda

The SDA Church offers smoking-cessation clinics.

Bolivia

In conjunction with CONLAT, the SDA Church offers cessation programs.

Brazil

Numerous companies offer classes and seminars. Banco do Brasil supports a systematic campaign against smoking that includes a cessation program.

British Virgin Islands

The SDA Church offers smoking-cessation clinics.

Cayman Islands

One private clinic and the SDA Church support smoking-cessation activities.

Chile

Cessation services are offered by the SDA Church, private physicians, and clinics. Primary health care providers are trained in smoking cessation, especially for women of childbearing age (as part of the Women's Health Plan).

Colombia

Cessation programs are offered by private clinics in Bogatá, Cali, and Medellín.

Costa Rica

The Institute on Alcoholism and Drug Abuse and the Social Security Fund sponsor cessation programs.

Ecuador

A pilot project for college-level students was coordinated by the ministries of health and education. The SDA Church offers cessation programs.

Honduras

The National Smoking Control Commission organizes workshops for community organizations, unions, student groups, and the general public, and the SDA Church offers cessation programs.

Jamaica

The SDA Church and several private practitioners offer smoking-cessation clinics.

Mexico

Cessation programs are offered in university hospitals in Mexico City and in hospitals in other states.

Netherlands Antilles

Health care providers support cessation activities.

Panama

Cessation programs are offered by the SDA Church, the Civic Support Committee for No Smoking Day, and the National Cancer Association. Most insurance companies use a nonsmoker life insurance premium differential of 10 to 25 percent.

Paraguay

The SDA Church and a Baptist hospital sponsor cessation programs.

Peru

The Young Men's Christian Association and the Inca Union (of the SDA Church) support cessation activities.

Puerto Rico

The Puerto Rican Lung Association sponsors clinics and physician training in smoking cessation. The American Cancer Society and the SDA Church sponsor clinics. Two insurance companies use a nonsmoker life insurance discount of one-third.

Trinidad and Tobago

The SDA Church sponsors clinics and classes.

Uruguay

The national school of medicine, the SDA Church, and many nongovernment organizations and private clinics offer cessation services.

U.S. Virgin Islands

The American Lung Association sponsors smoking-cessation clinics.

Venezuela

The SDA Church and Venezuelan Petroleum support cessation activities.

Appendix 2. Antitobacco Organizations in Latin America and the Caribbean

Organizations for the prevention and control of tobacco use are cited below (PAHO 1992).

Argentina

Coalition or program: Antismoking Action and Health Council (est. 1990)
Sponsor: Ministry of Health and Social Action, medical association, Rotary Club, Mainetti Foundation, Favaloro Foundation
Activities: Promotes community education, research, and legislation

Barbados

Coalition or program: National Drug Abuse Council
Sponsor: Ministry of Health
Activities: Includes tobacco in drug-abuse prevention activities and is planning data collection activities

Belize

Coalition or program: National Drug Abuse Advisory Council
Sponsor: Ministry of Health
Activities: Includes tobacco in drug-abuse prevention activities

Bolivia

Coalition or program: National Commission Against Tobacco Use (est. 1983)
Sponsor: Bolivian Cancer Foundation
Activities: Supports legislation, protects nonsmokers, reduces advertising, conducts research, and coordinates with international organizations

Brazil

Coalition or program: Advisory Group on the Control of Smoking; National Oncology Program (est. 1985)
Sponsor: Ministry of Health (National Cancer Institute, Respiratory Diseases Department), nongovernment organizations, religious groups, legislators, state health departments
Activities: Supports legislation, promotes prevention programs, and evaluates the national program by using public information, media, and surveillance

Chile

Coalition or program: Chronic Disease Program; National Commission for the Control of Smoking (est. 1986)
Sponsor: Government, medical association, nongovernment organizations
Activities: Sponsors educational planning, data collection, and international linkage

Colombia

Coalition or program: National Council on Smoking and Health (est. 1984)
Sponsor: Ministry of Health, National Cancer Institute, Colombian Cancer League, and a press representative
Activities: Conducts studies on tobacco control, taxation, contraband, and advertising restrictions

Costa Rica

Coalition or program: Costa Rican Social Security Fund; Institute on Alcoholism and Drug Abuse
Sponsor: Ministry of Health
Activities: Concerned with education, cessation programs, and legislation

Cuba

Coalition or program: National Program to Reduce Cancer Deaths (est. 1987)
Sponsor: Ministry of Health and 15 other government agencies
Activities: Develops public information, provincial working groups, legislation, and mass media messages

Dominican Republic

Coalition or program: Dominican Committee on Smoking and Health (est. 1989)
Sponsor: Nongovernment organization; Secretariat of Public Health and Social Welfare
Activities: Supports media activities and workshops

El Salvador

Coalition or program: Department of Mental Health
Sponsor: Ministry of Public Health and Social Welfare
Activities: Supports media campaigns and legislation

French overseas departments and territories

Coalition or program: French Committee on Health Education
Sponsor: French government
Activities: Distributes print materials to overseas departments and territories

Guatemala

Coalition or program: Mental Health Department; National Antismoking Commission
Sponsor: Ministry of Public Health and Social Welfare, government and nongovernment organizations, and physicians' association
Activities: Promotes public education and information, and international and national coordination of data collection, research, and government consultation

Guyana

Coalition or program: National Coordinating Council for Drug Education
Sponsor: Ministry of Health and nongovernment organizations
Activities: Develops school curriculum

Honduras

Coalition or program: Institute for the Prevention of Alcoholism and Drug Abuse (est. 1988)
Sponsor: Ministry of Public Health and Social Welfare
Activities: Coordinates government and nongovernment organizations, legislation, and school education

Coalition or program: National Smoking Control Commission
Sponsor: Nongovernment organizations
Activities: Supports local community action and World No-Tobacco Day

Jamaica

Coalition or program: National Council on Drug Abuse
Sponsor: Ministry of Health and nongovernment organizations (Jamaican Medical Association, Jamaican Cancer Society)
Activities: Promotes school education, public information, media activities, and legislation

Mexico

Coalition or program: National Committee for the Study and Control of Smoking (est. 1985)
Sponsor: Nongovernment organization
Activities: Offers advice on smoking and health programs

Coalition or program: Antismoking Program (est. 1986)
Sponsor: Secretariat of Health and National Council Against Addictions
Activities: Supports educational activities, improved treatment for persons with smoking-related illness, legislation, and research

Panama

Coalition or program: Adult Health Department (est. 1990)
Sponsor: Ministry of Health interdisciplinary group of professionals
Activities: Promotes prevention program for youths and sets guidelines for local action; reports on and evaluates prevention programs

Paraguay

Coalition or program: Paraguayan Antismoking Association
Sponsor: Nongovernment organizations
Activities: Encourages legislation and physicians' actions

Puerto Rico

Coalition or program: Coalition on Smoking and Health
Sponsor: Puerto Rican Lung Association, American Cancer Society, and American Heart Association
Activities: Supports legislation, education, media activities, and cessation programs

Suriname

Coalition or program: National Council on Drug Abuse
Sponsor: Nongovernment organizations, medical association, heart-disease patients, and sports association
Activities: Promotes public service announcements and school education

Uruguay

Coalition or program: Office on Smoking Control (est. 1988)
Sponsor: Ministry of Public Health (intersectoral)
Activities: Supports media activities, health care and community education, and publications

Venezuela

Coalition or program: National Antismoking Program (est. 1984)
Sponsor: Ministry of Health and Social Welfare
Activities: Promotes educational programs, media activities, and technical information

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